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Supplement 1 to Attachment 3.1-B
State: Wisconsin

DESCRIPTION OF LIMITATIONS

1. Eff. 4-1-93 Inpatient Hospital Services. Prior authorization is required for services provided outside the state by non-border status providers in non-emergency circumstances, for transplant services and for ventilator dependent services. Other professional services that require prior authorization outside the hospital, often require prior authorization when provided in a hospital.

Other limitations include, but are not limited to: circumstances for private room accommodations; restrictions on non-therapeutic sterilizations; requirements for separate billing of independent professional services; and restrictions to avoid duplicative and unnecessary payments.

2.a. Outpatient Hospital Services. Prior authorization restrictions apply to these services as required by the area of service.

2.b. Rural Health Clinic Services. Services provided by rural health clinics are subject to the same prior authorization requirements and other limitations as applied to covered services in the Medical Assistance Program.

4.a. Skilled Nursing Facility Services. Prior authorization is required for rental or purchase of a specialized wheelchair. Levels of service required are stipulated by the recipient's plan of care, subject to guidelines described in HSS 107.09(3).

4.c. Family Planning Services. Sterilization procedures require prior authorization and informed consent as mandated under federal regulations.

5. Eff. 4-1-93 Physician's Services. The Department imposes some payment and benefit limitations on some specific physician services. Many of these limitations are based on quantity and frequency, diagnoses, provider specialty, or the place the service is provided. In addition, some procedures require prior authorization and/or a second surgical opinion. Examples of physician services in each of these areas are listed below:

Services with Quantity and Frequency Limitations - Services with quantity and frequency limitations include: evaluation and management visits in the office, outpatient clinic and inpatient hospital nursing home; routine foot care; specific injections; weight alteration programs; fetal monitoring; clozapine management, and multiple surgeries performed on the same day.

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

Services with Diagnosis Limitations - Services with diagnosis limitations include: certain injections, routine foot care and application of Unna boots.

Services with Provider Specialty Limitations - Provider specialty limitations are imposed on physicians providing obstetric and pediatric services, and those performing evoked potentials testing.

Services with Place of Service Limitations - Place of service limitations are imposed on medication management in the home and on critical or prolonged care provided in the emergency department.

Services that Require Prior Authorization - To insure that a procedure is medically necessary, to demonstrate that the procedure is not primarily cosmetic or for the convenience of the recipient, to assure that the procedure is not experimental in nature, and to allow the Department to determine the treatment is the most cost-effective available, the provider must obtain prior authorization for the following categories of procedures:

1) Surgical or other medical procedures of questionable medical necessity but deemed by the Department to be essential to correct conditions that cause significant impairment to the recipient's interpersonal adjustments or employability;

2) Surgical procedures or medical procedures that the Department deems redundant, outdated or marginally effective;

3) Transplants;

4) Sterilizations (to conform with federal and state regulations and limitations);

5) Temporomandibular surgery.

Second Surgical Opinion - Elective surgeries that require the recipient obtain a second surgical opinion include but are not limited to: cataract extraction; cholecystectomy; hemorrhoidectomy; diagnostic D & C procedures; inguinal hernia repair; hysterectomy; joint replacement, hip or knee; tonsillectomy/adenoidectomy; varicose vein surgery.

State: Wisconsin

5.b. Eff. 10-1-91

Dental Services. The same prior authorization and other limitations required under item #10 and 12.b. apply.

6.a. Eff. 7-1-90

Podiatry Services. Prior authorization is required for electric bone stimulation. Maintenance care is limited to once per 61 day period under certain conditions. For other service limitations, see. s. DHS 107.14(3), Wis. Adm. Code. All orthopedic and orthotic services, including repairs, orthopedic and corrective shoes and supportive devices, services correcting "flat feet," and treatment of subluxation of the foot are not covered.

6.b. Eff. 1-1-93

Vision Care Services. (Optometry) Prior authorization is required for certain types of lenses and frames, antiseikonic services, prosis crutch services, low vision services, certain opthalmological services and vision training. Frames, lenses and replacement parts must be obtained through the volume purchase plan provider, unless prior authorized. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

6.c. Eff. 3-1-86

Chiropractic. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. Consultations are not covered.

6.d. Eff. 4-1-93

Other Practitioners

Other Nurse Practitioners and Clinical Nurse Specialist Services.
Included are other primary care nurse practitioner and clinical nurse specialist services not covered under item #23. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intraveneously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

Pharmacists.
Pharmacists may be reimbursed for the administration of the 2009 H1N1 vaccine to the extent permitted by Wisconsin law. The vaccine itself will be provided by the Federal Government and provided free of charge.

Effective 10/01/2009

Eff. 7-1-95

Clozapine Management. Clozapine Management is a covered service when all of the following conditions are met:

- a physician has prescribed clozapine,
- the recipient is currently taking clozapine or has taken it within four weeks,
- the dispensing pharmacy has received prior authorization for clozapine,
- the provider of clozapine management has received prior authorization for that service.

Providers of clozapine management work under the general supervision of a physician or a pharmacist and include Medicaid-certified, licensed pharmacies and Community Support Programs (CSP). Qualified pharmacy staff include pharmacists, nurses, pharmacy technicians and others with equivalent training, knowledge and experience. Qualified CSP professional staff are designated in the approved CSP treatment plan component regarding clozapine management services.

Components of clozapine management include the following services as appropriate:

a. Ensuring the recipient has the required weekly white blood count testing. The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. To perform this service, the provider may travel, if necessary, to the recipient's residence or other places in the community where the recipient is available.

b. Ensuring the blood test results are reported in a timely fashion to the pharmacy dispensing the recipient's clozapine.

c. Ensuring abnormal blood test results are reported to the physician who prescribed the recipient's clozapine.

d. Ensuring the recipient receives medications as scheduled, ensuring the recipient stops taking medication when the blood test is abnormal, if so ordered by the physician, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being are maintained.

e. Making arrangements for the transition and coordination of the use of clozapine and clozapine management services between different care locations.

f. Maintaining appropriate records.

and medication MS as defined below

7. Eff. 7-1-92 Home Health Care Services. Home health skilled nursing and therapy services, including medication management, are provided to a recipient who, due to his/her medical condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home.

However, a recipient who can leave the home but cannot reasonably be expected to obtain this care outside the home, or cannot obtain medically necessary services from an appropriate provider outside the home may receive home care. Medically necessary home health aide services are available, irrespective of the recipient's ability to leave his/her residence.

6.d. Other practitioners, continued

I. **Medication Therapy Management Services Performed by a Pharmacist**

The Medication Therapy Management (MTM) benefit consists of services that are provided by qualified, licensed pharmacists to members to optimize the therapeutic outcomes of a recipient's medications and reduce costs. These services are delivered in a face-to-face setting. This benefit is voluntary and is available for members in Wisconsin Medicaid, BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and BadgerCare Plus Core Plan. The MTM benefit will include two types of services:

A. Intervention-Based Services - These are focused interventions between pharmacists and members, such as instructing a patient on using a medication device, filling a pill box for a member, or recommending a change to a member's prescription when the member has an adverse reaction to the medication.

1. The prescriber must approve changes to the member's drug regimen.
2. All members enrolled in a qualifying plan are eligible for this service.
3. Four of the same intervention-based services are reimbursable per member, per rolling year, with the exception of the following services for which there is no annual limit:

- Formulary interchanges
- Therapeutic interchanges
- Tablet-splitting opportunities
- Conversion to an over-the counter product
- Dose consolidation
- Converting a prescription from a one-month supply to a three-month supply (this is limited to one intervention, per drug, per rolling year)

B. Comprehensive Medication Review and Assessment (CMR/A) – These are comprehensive interventions between providers and members. They involve an in-depth, interactive review of the member's medication regimen, health history and lifestyle.

6.d. Other practitioners, continued

I. **Medication Therapy Management Services Performed by a Pharmacist, continued**

1. A member may be eligible for this service if he/she meets at least one of the following criteria:
    - Is taking four or more medications used to treat or prevent two or more chronic conditions.
    - Has diabetes.
    - Has recently been discharged from the hospital or a long term care setting.
    - Has experienced health literacy issues.
    - Was referred by a prescriber due to issues that are impacting the member's health.
    - Meets other criteria as defined by the Department.
2. The provider must be certified by a Department-approved certification program before providing a CMR/A.
3. Providers must have a private or semi-private area in which to conduct the CMR/A.
4. One initial assessment and three follow-up assessments are reimbursable per member, per rolling year.

Providers may receive Department approval to exceed annual limits for the intervention-based services and CMR/As for children who are EPSDT-eligible and for members who demonstrate medical need.

Similar to Medicare, a visit may be of any duration, with prior authorization required after 30 visits of any combination of RN, LPN, home health aide or therapy services. Skilled nursing and therapy services are available for recipients who require less than eight hours of a day with home health aide services provided up to 24 hours a day as the recipient's condition requires. Various limitations apply based on appropriate nursing practices, state licensure, and Medicare/Medicaid certification requirements.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

7.c. 1-1-93 Medical Supplies and Equipment. The Department requires prior authorization or imposes payment and benefit limitations for the repair, modification, rental or purchase of most medical supplies and equipment to enable the Department to monitor and regulate the following: cost, frequency, place where the recipient receives the service, and recipient's medical diagnosis or functional conditions under which the items will be reimbursed. These medical supplies and equipment include, but are not limited to: durable medical equipment, disposable supplies, hearing aid and related materials, and orthoses.

The following medical supplies and equipment are not covered: items that are not primarily medical in nature, are not proven to be therapeutically effective, or do not contribute to the improvement of a recipient's medical or functional condition; and items or features that are primarily for a recipient's comfort and convenience.

7.d. Eff. 3-1-86 Physical, Occupational and Speech Therapy and Audiology Provided by Medical Rehabilitation Facility. The prior authorization requirements and other limitations are described below in item #11.

8. Eff. 1-1-92 Private Duty Nursing. Prior authorization is required for all private duty nursing services. These services may be provided only if the recipient requires 8 or more hours of skilled nursing care a day.

9. Eff. 3-1-86 Clinic Services. All prior authorization requirements for services apply as appropriate. Second surgical opinion requirements also apply (see #5 above).

10. Eff. 10-1-95 Dental Services. Dental services are limited to the basic services within each of the following categories: diagnostic services, preventive services, restorative services, endodontic services, periodontic services, fixed and removable prosthodontics, oral and maxillofacial services, and emergency treatment of dental pain. The following are examples of services not covered: dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontal services; alveoplasty and stomoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

11. Eff. 3-1-06 Physical Therapy and Related Services. Prior authorization is required for physical and occupational therapies, and speech language pathology after 35 treatment days per spell of illness. A spell of illness means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the severity of a pre-existing medical condition. Services for recipients who are hospital inpatients or receiving therapy through a home health agency are not subject to this requirement. For audiology, prior authorization is required for speech and aural rehabilitation.

Physical therapists provide physical therapy services, occupational therapists provide occupational therapy services, and speech-language pathologists provide speech, hearing and language services. Physical therapists are certified under s. DHS 105.27 and meet the requirements of 42 CFR 440.110 (a). Occupational therapists are certified under s. DHS 105.28 and meet the requirements of 42 CFR 440.110 (b). Speech language pathologists are certified under s. DHS 105.30 and meet the requirements of 42 CFR 440.110 (c). Those who provide services under the direction of the listed therapists are physical therapist assistants, who are certified providers under ch. DHS 105.27, and occupational therapy assistants, who are certified providers under s. DHS 105.28.

12. Prescribed Drugs.

1. Drugs and drug products covered by MA include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index, which are prescribed by a licensed physician, nurse prescriber, dentist, podiatrist, or optometrist or when a physician delegates prescription of drugs to a nurse practitioner or to a physician's assistant.

2. Drugs excluded from coverage include drugs determined to be "less than effective by the FDA, drugs not covered by a federal rebate agreement, experimental drugs or other drugs that have no medically accepted indications, and other items as enumerated in Wisconsin Administrative Code, such as personal hygiene items, cosmetic items, and common medicine chest items.

3. To be a covered service, an over-the-counter drug shall have a signed federal rebate agreement and be listed in the Wisconsin Medicaid drug index. General categories of OTC drugs that are covered include the following: antacids, analgesics, insulins, contraceptives, cough preparations, opthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

Effective 08/15/2003

12.a. Prescribed drugs, continued.

Prior Authorization

1. Prescription drugs may be subject to prior authorization by DHFS to ensure that drugs are prescribed and dispensed appropriately.

2. DHFS determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following: safety; potential for abuse or misuse; narrow therapeutic index; and high cost when less expensive therapeutically equivalent alternatives are available.

3. DHFS will convene a Prescription Drug Prior Authorization Committee comprised of at least two physicians, two pharmacists, and one advocate for Medicaid recipients to review the pertinent scientific literature and make prior authorization recommendations to the Department.

4. As enumerated in Wisconsin Administrative Code, all Schedule III and IV stimulant drugs as listed in the Wisconsin Medicaid Drug Index; enteral and parenteral nutrition products; fertility drugs used for treatment of a condition not related to fertility; impotence drugs used for treatment of a condition not related to impotence; drugs that have been demonstrated to entail substantial cost or utilization problems for the MA program; and drugs produced by a manufacturer that has not signed a federal rebate agreement but which are medically appropriate and cost effective treatment for a recipient's condition as certified by the prescribing provider are subject to prior authorization.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its state-sponsored portion of SeniorCare.

12.a. Prescribed drugs, continued.

6. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and for the dispensing of a 72-hour supply of medications in emergency situations.

7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented, in compliance with federal law.

8. Claims management is electronic, in compliance with federal law.

9. The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the federal rebate program. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers may audit utilization data. The unit rebate amount is confidential and may not be disclosed for purposes other than rebate invoicing and verification.

10. The state will participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as The Optimal PDL $olution (TOP$). TOP$ rebate agreements will be separate from the federal rebates. TOP$ supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

11. A TOP$ rebate agreement for drugs provided to the Medicaid program has been authorized by CMS.

12. Pursuant to 42 USC 1396r-8, the state is establishing a preferred drug list with prior authorization requirements for drugs not included on the preferred drug list.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency Wisconsin

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

The following excluded drugs are covered:

☑ (a) agents when used for weight loss

Meredia, Didrex, Phentermine, Ionamin, Diethylpropion, Bontril, and Xenical. Coverage is for both the brand name and generic formulations of the aforementioned weight loss agents.

☐ (b) agents when used to promote fertility (see specific drug categories below)

☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)

☑ (d) agents when used for the symptomatic relief cough and colds

☑ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride

☑ (f) nonprescription drugs

Prilosec OTC (coverage terminates 4/1/06)

Antacids, analgesics, contraceptives, cough preparations, antihistamines, opthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Wisconsin

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

☑ (h) barbiturates

Effective for dates of service on and after January 1, 2013, barbiturates will become Medicare Part D-covered drugs when used for cancer, epilepsy, or chronic mental health disorder diagnoses. Claims for barbiturates for full benefit dual eligible beneficiaries with these diagnoses should be submitted to Medicare Part D.

☑ (i) benzodiazepines

Effective for dates of service on and after January 1, 2013, benzodiazepines will become Medicare Part D-covered drugs. Claims for benzodiazepines for full benefit dual eligible beneficiaries should be submitted to Medicare Part D.

☑ (j) prescription smoking cessation products (except as Medicare Part D will cover for dual eligibles)

12.b. Dentures. Prior authorization is required.

12.c. Prosthetic Devices. Prior authorization is required for most prostheses, hearing aids, and other
Eff. medical equipment in the Wisconsin Durable Medical Equipment and Supplies indices, except
1-1-93 for certain opthalmological prostheses. Prior authorization also is required for most items not in the indices.

12.d. Eyeglasses. When frames and lenses services are provided by the same provider, prior
Eff. authorization is required to exceed the following limitations in a 12 month period: one original
1-1-93 pair; one unchanged prescription replacement pair; and one replacement pair with a documented changed prescription meeting Department criteria. Tinted lenses, occupational frames, certain glass and lens types and frames and other vision materials not obtained through the volume purchase plan also require prior authorization. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

13.d. Rehabilitative Services.
Eff.
1-1-93 Community Support Program Services. Community Support Programs (CSP) provide a compendium of medical and psychosocial/rehabilitative services, enabling the recipient to better manage the symptoms of his/her illness, to improve independence, and to achieve effective levels of functioning in the community. Recipients able to benefit from mental health treatment and restorative services provided in a community setting on a long-term basis will experience a reduction in the incidence and duration of institutional care they might otherwise need.

An MA recipient who is eligible for these services has a diagnosed, severe long-term illness which puts the person at significant risk of continued institutionalization. The recipient is seriously impaired in the basic areas of everyday functioning, and traditional mental health outpatient treatment on a regular basis for at least a year has proven ineffective.

Agencies providing MA CSP services must be certified by the Department of Health and Social Services. Certification requires that direct supervision of treatment staff providing services is performed by a clinical coordinator who has appropriate education and clinical experience with long-term mentally ill persons; a psychiatrist must be available to provide direction and necessary psychiatric services; an in-depth assessment is completed within 30 days; and a comprehensive treatment plan is developed and reviewed at least every six months.

Services are focused on increasing the recipient's ability to gain and maintain normal functioning in the community and at home. Following in-depth assessment and mental health treatment planning, rehabilitative treatment and activities are structured to ameliorate the effects of illness on the recipient's ability to perform personal care and social activities of every-day living. Restorative care is provided to enable the recipient to seek and maintain employment; to obtain necessary medical, legal, financial and governmental services; and to acquire and maintain adequate housing. In addition, a medical treatment component affords family, individual and group psychotherapy, medication administration and monitoring, 24-hour crises intervention, and ongoing psychiatric and psychological evaluation. Finally, community support program services include case management ongoing monitoring and service coordination activities. The majority of psychosocial/rehabilitative treatment activities as well as medical treatment is provided in the community or the recipient's home to afford maximum support for the recipient in meeting treatment goals.

CSP services may include Clozapine management. See description under 6d. Other Practitioners.

Eff. 10-1-96

13.d Mental Health Crisis Intervention Services

Mental Health Crisis Intervention (MHCI) services are a coordinated system of mental health services that provides an immediate response to assist a person experiencing a mental health crisis. "Crisis" means a situation caused by an individual's apparent mental disorder:

- that results in a high level of stress or anxiety for the individual, for the persons providing care for the individual or for the public, and
- that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

An initial assessment and referral to services, if appropriate, either over the telephone or face-to-face is available to any recipient contacting a MHCI provider. Additional crisis linkage, follow-up and stabilization services are available only to recipients determined to be in crisis. Services are described in a response plan or a crisis plan for individuals known to require periodic crisis intervention, and are approved by a psychiatrist or a licensed psychologist. Interventions are designed to relieve the recipient's immediate distress, reduce the risk of escalation, reduce the risk of physical harm to the recipient or others, resolve the crisis and improve individual and family coping skills, coordinate the involvement of other resources needed to respond to the crisis and assist the recipient to make the transition to the least restrictive level of care required. Services may be provided in the office setting, over the telephone, in the home or in the community. Services to individuals residing in a hospital or nursing facility are limited to development of the response plan or crisis plan and those services required to assist the recipient to transition to the least restrictive level of care required, but may not duplicate the hospital's or nursing facility's discharge planning activities. Services may be provided directly to the recipient or to others involved with the recipient when such intervention is required to address the recipient's crisis. Services for individuals receiving Medicaid Community Support Program (CSP) services are allowed when:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program and the CSP.
- The crisis intervention services do not duplicate CSP services.

Substitute page received 3-7-97

While MHCI services are available in each county, agencies providing Medicaid MHCI services must be certified by the Department's Division of Supportive Living certification standards which include staff qualifications, supervision requirements, service standards and requirements for a coordinated emergency mental health services plan. Services must be available 24 hours a day, 7 days a week.

Services billed and reimbursed as MHCI services may not also be billed and reimbursed as another MA service, such as hospital outpatient services, community support program services, day treatment services, outpatient psychotherapy services or case management services. Room and board costs are not covered under MHCI services. Services that are primarily social or recreational are not covered under MHCI services.

Substitute page received 3-7-97

Eff. 1-1-93

Medical Day Treatment - Mental Health Service. Medical day treatment is a mental health rehabilitation service for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional, outpatient mental health treatment is not adequate to stabilize their condition, attain their best possible functional level, or maintain their residence in the community. This service also is appropriate on a limited basis for individuals in hospitals or nursing facilities who are in transition from an institutional to a community setting. Day treatment services are necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level.

Medical day treatment is a compendium of medical, mental health, occupational therapy, and other services. Specific day treatment services include individual and group occupational therapy and psychotherapy, medication management, symptom management, psychosocial rehabilitation services, and nursing services. Medical Assistance pays only for those medically-necessary services in a physician-approved plan of care, provided under the general direction of a physician.

Medical day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires the following: a registered nurse or occupational therapist is on duty to participate in program planning, implementation, and coordination; the program is directed by an interdisciplinary team; a qualified professional staff person participates in all groups; and periodic evaluation is conducted of each recipient's progress in the program.

13.d Medical Day Treatment - Mental Health Service. (Continued)

Prior authorization is required after a limited number of hours of service have been provided in a calendar year. Any occupational therapy and psychotherapy provided as part of the day treatment program are part of the day treatment benefit, are subject to day treatment limitations, and cannot be separately billed.

Activities such as recreation, arts and crafts, music, exercise, socializing, and general education that may be part of a recipient's day treatment program, are non-covered services.

Eff. 1-1-93 Outpatient Psychotherapy Services. The Medical Assistance Program covers outpatient psychotherapy services necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level. These services are available to recipients when prescribed by a physician prior to beginning treatment.

Evaluations, assessments and testing are provided to all recipients to determine the need for psychotherapy services or to evaluate the appropriateness of the services being provided.

Treatment services include individual, group, and family psychotherapy (including such modalities as hypnotherapy and biofeedback) and collateral contacts. Psychiatric medication management may be provided by physicians or registered nurses employed by a certified clinic.

Outpatient psychotherapy services are provided under the direction of a psychiatrist or licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology. These services may be performed by either such a psychiatrist or psychologist, or by an individual with a master's degree in social work, counseling, psychology, or a related discipline, who has 3000 hours of post-degree experience providing psychotherapy services and who is supervised by a provider meeting the certification requirements. Masters level providers must work in an outpatient clinic certified by the Department of Health and Social Services.

Prior authorization is required for recipients to receive services beyond an identified dollar or hourly limit in a calendar year. (This threshold also includes outpatient AODA services provided to the same recipient.) Evaluations require prior authorization after reaching an hourly limit in a two year period.

Eff. 10-1-97 Mental health services, including services provided by a psychiatrist, may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

13.d Outpatient Alcohol and Other Drug Abuse (AODA) Treatment Services.

Eff. 1-1-93 Outpatient AODA treatment services are available to recipients when such services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level. A physician's prescription is required before starting AODA treatment services.

Outpatient AODA services include evaluations, assessments and diagnostic services to determine the need for AODA services or to evaluate the appropriateness of the services being provided. The outpatient AODA treatment services include individual, group, and family AODA treatment and AODA educational programming specific to medical aspects of AODA diagnosis and treatment.

Medication management may be provided by physicians, or registered nurses employed by a certified clinic. Counseling services include counseling necessary to ensure the best possible level of functioning associated with methadone maintenance. All services are provided under the general direction of a physician.

These services may be performed only by the following providers: a physician; a licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology; an individual with a master's degree in social work, counseling or psychology, or a related discipline, who has 3000 hours of post-degree experience providing psychotherapy services supervised by a provider meeting the certification requirements; or an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III. Masters level providers and AODA counselors must work in outpatient clinics certified by the Department of Health and Social Services.

Prior authorization is required for AODA treatment services after the recipient has received a specified dollar or hourly limit of services in a calendar year. (This threshold also includes outpatient psychotherapy services provided to the same recipient.) Detoxification is not covered in a social (non-hospital) setting.

Eff. 1-1-93

Alcohol and Other Drug Abuse (AODA) Day Treatment. AODA day treatment is available for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional, outpatient treatment is not adequate to stabilize their condition or attain their best possible functional level in the community. AODA day treatment may be appropriate for individuals who have had inpatient hospital detoxification or limited inpatient hospital rehabilitation. These services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level.

AODA day treatment is a compendium of medical and AODA treatment services, but Medical Assistance pays for only those services which are medically necessary based on a supervising physician or psychologist-approved plan of care and are provided under the general direction of a physician. Medical Assistance-covered services include individual, group, and family therapy and educational programming specific to medical aspects of AODA diagnosis and treatment.

AODA day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires that the program be directed by an interdisciplinary team; that an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III is on duty all hours in which services are provided; and that recipients are evaluated for their ability to benefit from treatment.

All AODA day treatment services must be prior authorized except for the initial three hours of assessment. A recipient may not receive outpatient AODA services during the period he or she is receiving AODA day treatment.

Eff. 10-1-97

Alcohol and other drug abuse services may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

Activities such as recreation, arts and crafts, music, exercise, socializing and general education which may be part of the recipient's day treatment program are non-covered services by Medical Assistance.

14. Eff. 7-1-87 Services for Individuals Age 65 - In Institutions for Mental Diseases. Prior authorization and other limitations which otherwise are required for SNF or ICF care apply here. See Item #4a of this section and HSS 107.09, Wis. Adm. Code.

17. Eff. 10-1-93 Nurse Midwife Services. Nurse midwife services are subject to limitations within the scope of practice of the nurse midwife. The scope of practice is the overall management of care of a woman in normal childbirth and the provision of prenatal, intrapartal, postpartal and nonsurgical contraceptive methods and care for the mother and the newborn up to one year of age. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Nurse midwife services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

18. Eff. 7-1-88 1-1-91 Hospice Care Services. This service is provided according to federal requirements, including amendment by P.L. 101-508 (OBRA '90).

19. Eff. 10-1-97 Case Management Services.

Case Management is not available to any recipient:

a. participating in a home and community based (1915(c)) waiver program,

b. residing in an MA funded institution (e.g., hospital or nursing home), except for discharge-related case management services prior to discharge from an institutional setting,

c. in excess of one assessment or case plan per calendar year, per county, except when recipients receive prenatal care coordination,

d. in excess of one claim for ongoing monitoring per month per county except when recipients receive prenatal care coordination, or

e. enrolled in a MA-certified community support program.

Case Management does not include:

a. services which are diagnostic or therapeutic or which could be paid for by MA as any other covered benefit by certified or certifiable professionals,
b. legal advocacy by a lawyer or paralegal,
c. personal care or supportive home care,
d. client education and training, or
e. services not provided or directed towards some specific recipient.

19.b. Eff. 7-1-95

Special Tuberculosis Related Services under Section 1902(z)(2)(F)

These services are limited to those recipients with a TB-related diagnosis and include directly observed therapy, in-home monitoring of TB-symptoms, patient education and anticipatory guidance, and disposable supplies to encourage the completion of prescribed drugs.

20. Extended Services to Pregnant Women

Eff. 9-1-87

Major Categories of Service

Major categories of services are: inpatient and outpatient hospital services, physician services, laboratory and x-ray services, rural health and other clinic services, and diagnostic services. These include routine prenatal care, labor and delivery, routine post-partum care and complications of pregnancy or delivery likely to affect the pregnancy. These services are subject to the same limitations which pertain to the respective areas of service.

Eff. 1-1-93

Health Education

Health education for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary instruction to ameliorate a pregnant woman's identified risk factors, as determined by the Department-sanctioned risk assessment. The following areas may be included:

1. education/assistance to stop smoking and to stop alcohol and addictive drug consumption;
2. education/assistance to stop potentially dangerous sexual practices;
3. lifestyle management and reproductive health;
4. education/assistance to handle environmental/ occupational hazards;
5. childbirth and parenting education.

Nutrition Counseling

Nutrition counseling for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary nutrition instruction and guidance to ameliorate a pregnant woman's identified risk factors as determined by the Department-sanctioned risk assessment, and may include, but is not limited to, the following areas:

1. weight and weight gain;
2. biochemical and dietary factors;
3. previous and current nutrition-related obstetrical complications;
4. psychological problems affecting nutrition; and
5. reproductive history affecting nutritional status.

21. Eff. 9-1-87 Ambulatory Prenatal Care for Pregnant Women. These services are subject to the same limitations which pertain to the respective areas of service.

22. Eff. 1-1-99 Respiratory Care Services. Prior authorization of services is required for reimbursement. The recipient will have been medically dependent on a ventilator for life support for at least six hours per day. In addition, the recipient will meet one of the following two conditions:

- The recipient will have been so dependent for at least 30 consecutive days as an inpatient in one or more hospitals, nursing facilities, or ICF/MR, as stated in 42 CFR 440.165(a)(2).
- If the recipient has been hospitalized for less than 30 days, the recipient's eligibility for services will be determined by the Division's Chief Medical Officer on a case-by-case basis, and may include discussions with the recipient's pulmonologist and/or primary care physician to evaluate the recipient's prognosis, history of hospitalizations for the respiratory condition, diagnosis, and weaning attempts, when appropriate.

Reimbursement under the respiratory care benefit is not available for services that are part of the rental agreement for a ventilator or other necessary equipment with a durable medical equipment provider. Respite services are not covered.

23. Eff. 4-1-93 Pediatric or Family Nurse Practitioner Services. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

24. Any Other Medical Care

a. Transportation Services Non-emergency transportation by air and water ambulance requires prior authorization. Ambulance service restrictions include, but are not limited to: medical order requirements for non-emergency services, trip purpose limitations, and pick-up and destination point limitations.

Specialized motor vehicle transportation services are provided only to recipients with prescriptions documenting their inability to use common carrier transportation (such as private auto, bus, taxi). Eligibility standards are established for second attendant services. Within Department-established restrictions, unloaded mileage is a covered service utilizing specified mileage zones. Trips over a specified upper mileage limit require prior authorization.

b. Transportation for School-Based Services (SBS):

1. Transportation to School.

A child's transportation to and from a school certified as an SBS provider is a covered service only if all of the following conditions are met:

- The child receives covered SBS services identified in the child's IEP at the school on the day the transportation is provided.
- The SBS provider is financially responsible for providing the transportation.
- The child's medical need for the particular type of transportation is identified in the IEP.
- The vehicle is equipped with and the child requires a ramp or lift, an aide is present and the child requires the aide's assistance in the vehicle or the child has behavioral problems that do not require the assistance of an aide but that preclude the child from riding on a standard school bus.

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2. Off-site transportation. A child's transportation to and from a site other than the child's "home" school is a covered service only if all of the following conditions are met:

   - The child receives covered SBS services identified in the child's IEP at the site on the day the transportation is provided.
   - The SBS provider is financially responsible for providing the transportation.
   - The transportation is either from the school to an off-site provider and back to school or to home, or is between home and a "special" school. A "special school" is a school that requires that a child have a disability in order to be enrolled, including but not limited to the Wisconsin School For The Deaf or the Wisconsin School For The Visually Handicapped, as defined in ch. PI 12, Wis. Adm. Code.

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d. Nursing Facility Services for Recipients Under 21 Years of Age. The plan of care and independent medical review provide bases for authorization and payment amount.

e. Non-Emergency Out-of-State Treatment. Prior authorization is required for all non-emergency out-of-state procedures unless the provider has been granted border status.

24.f. Eff. 2-25-94 Personal Care Services. Prior authorization is required for personal care services after a limited number of hours of service have been provided in a calendar year.

Services must be supervised by an RN who reviews the plan of care, the performance of the personal care worker and evaluates the recipient's condition at least every 60 days. Reimbursement for RN supervisory visits is limited to one visit per month.

Eff. 1-1-89 Personal care workers can perform home health aide tasks when delegation, training and supervision criteria are met. Housekeeping tasks performed by the personal care worker are limited to 1/3 of the time spent in the recipient's home.

Eff. 1-1-98

HealthCheck (EPSDT) Other Services

In addition to services provided elsewhere in this Plan, HealthCheck (EPSDT) recipients may receive, if medically necessary and prior authorized, the following services:

1. Mental Health
   a. In-home psychotherapy
   b. Mental health day treatment
   c. Specialized psychological evaluation for conditions, such as children with sexually deviant behavior, where a limited number of providers are qualified. The evaluation includes components not included under outpatient psychotherapy services.
2. Dental
   a. Oral examinations exceeding the limitations for adults
   b. Single unit crowns
3. Otherwise Non-Covered Over-the-Counter Medications

   Certain commonly required medications such as multivitamins require only a prescription and not prior authorization.